Downtown Dental

Your smile. Our tradition

CONSENT FOR SERVICES

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Downtown Dental to use and disclose my protected health information to carry out the following:

• Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

• Obtaining payment from third-party payers (i.e. insurance companies) or other financial institutions (i.e. credit card companies, financing companies);

• The day-to-day healthcare operations of Downtown Dental.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that Downtown Dental reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that Downtown Dental is not required to agree to these requested restrictions. However, if Downtown Dental does agree, then Downtown Dental is bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize Downtown Dental to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Signature of Patient, Parent, or Guardian____

Date ______________________

Patient Name: ____

Relationship to Patient: _____________________________________